NHS Greater Glasgow & Clyde
Food Fluid and Nutritional Care Planning and Implementation Group (PIG)

NHS
Greater Glasgow and Clyde

Standard Operating Procedure (SOP) for the management of oropharyngeal dysphagia

ACUTE ADULT SETTING

Aim

This SOP provides additional **acute specific information** relating to the local application of the **'Policy for the Management of People with Swallowing Difficulties as a Result of Oro-pharyngeal Dysphagia across NHS Greater Glasgow and Clyde (NHSGGC)'**

The aim of the above policy is to ensure a **consistent, standardised approach to the management of oropharyngeal dysphagia** across the variety of in-patient settings. The policy promotes individualised, patient centred care and encourages joint decision making, particularly in relation to consent and capacity issues, advanced directives and/or expressed wishes.

Scope

The above Policy deals with **dysphagia involving the oral cavity and pharynx. Oesophageal swallowing disorders are not covered by this document.**

The full policy covers all children and adults, within NHSGGC and applies to all clinical and healthcare staff involved with the care of patients with oropharyngeal dysphagia.

Statement

All HCW must adhere to the 'Policy for the Management of People with Swallowing Difficulties as a Result of Oro-pharyngeal Dysphagia across NHS Greater Glasgow and Clyde (NHSGGC)' and to the associated **standard operating procedure** for the management of oropharyngeal dysphagia in acute settings.

Monitoring and Review

This SOP will be reviewed in line with review of the policy.

1. Screening and Referral

- Nursing staff completing the administration process for new admissions will check for existing swallowing difficulties.
- Nursing staff will document and share any current recommendations with all relevant MDT staff at the admission stage.
- Where existing oropharyngeal dysphagia is identified without suspicion of new changes and where diet, fluid or swallowing recommendations are already in place (as outlined in patient notes area of Clinical Portal), nursing staff will order relevant diet and fluids for the patient.
- A 'Safer Swallowing Recommendations' sheet will be completed by ward staff detailing the relevant existing recommended diet. This will be retained for reference according to local processes.
- Where existing oropharyngeal dysphagia is identified and no information is known regarding diet, fluid or swallowing recommendations, Nursing staff will check the patient's usual diet and fluids at home.
- Where new oropharyngeal dysphagia is identified nursing staff will follow the existing process and complete STOPSS (Screening Test for oro-pharyngeal swallowing symptoms).
- A 'Safer Swallowing Recommendations' sheet will be completed by ward staff detailing the advised recommendations. This will be retained for reference according to local processes.
- Nursing staff will refer relevant patients to Speech & Language Therapy (SLT) according to the existing STOPSS process via Trakcare. Referrals can only be accepted via this method.
- Patients referred to SLT will normally be responded to within 2 working days.

2. Assessment and Recommendations

- SLT will advise and assess as required (please refer to main policy document)
- SLT will document the assessment outcome, recommendations and team communication under 'Patient Notes' in the clinical portal.
- A 'Safer Swallowing Recommendations' sheet will be completed by the SLT with the advised recommendations and retained for reference according to local processes The SLT will discuss documentation and recommendations with ward staff including the proposed plan.
- Nursing staff are responsible for ensuring that recommendations are shared with all relevant parties as appropriate (ward staff, Multi-Disciplinary Team colleagues, staff issuing refreshments, family/carers, visitors, MDT etc).
- SLT assessment may result in recommendations for diet and fluid modification and will employ the relevant consistent use of terminology i.e. IDDSI (International Dysphagia Diet Standardisation Initiative) terminology for diet and fluid modification.
- SLT assessment may also result in recommendations for the use of swallowing strategies or advice as indicated (please refer to main policy document).
- SLT assessment may result in recommendation for further investigation (e.g. video-fluoroscopy) or consideration of alternative methods of nutrition/hydration (e.g. enteral feeding tube).
- SLT will review and revise recommendations if required.
- SLT will liaise with receiving SLT on discharge from hospital if follow up as required.

Acute In-patient Oropharyngeal Swallowing Problems - Standard Operating Procedure

(Please see NHSGGC Food, Fluid and Nutrition web pages for further information)

Admission

Admission process must include consideration of oropharyngeal dysphagia (Liaison with patient, carer, relevant others regarding history. Consider capacity and wishes, current diet and fluids and initial clinical findings). Identify whether admission is dysphagia related.

Acute / longstanding

Acute, new orophparyngeal dysphagia identified

Longstanding or changing oropharyngeal dysphagia identified

Baseline function

Establish and fully document **new oropharyngeal dysphagia**. This should include estimated risk, symptom details and duration/ change, initial assessment findings and initial MDT management plan.

Establish and fully document **pre-existing or changed oropharyngeal dysphagia.** This should include estimated risk, symptom details and duration/ change and any existing management plans (such as texture modified diet/fluids or other strategies to reduce aspiration risk).

Team Communication

Ensure any new oropharyngeal difficulties are **confirmed, discussed within the MDT and fully documented** on admission (including consideration of ethical, legal and patient/carer views)

Ensure any pre-existing or changed oropharyngeal difficulties are **confirmed, discussed within the MDT and fully documented** on admission (including consideration of ethical, legal and patient/carer views)

Current status

Establish current symptom status - Deteriorating/stable/ improving

Establish current symptom status - Deteriorating/stable/ improving

Action

Acute/deteriorating: Follow existing screening process (**STOPSS)**

Chronic stable: Ensure access to current recommended diet and fluids with monitoring for change. Ensure appropriate above bed signage in place

NHSGGC Guideline: Eating and Drinking with Accepted Risk